Client-identified helpful and hindering events in therapist-delivered vs. self-administered online cognitive-behavioural treatments for depression in college students

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The study investigated what participants found helpful and/or hindering in therapist-delivered vs. self-administered online cognitive-behavioural therapy (CBT) for depression. A descriptive–interpretive analysis was used to investigate client-identified helpful and hindering events and impacts in online treatment. Eighty participants with symptoms of depression were randomly allocated to either eight sessions of therapist-delivered asynchronous e-mail CBT counselling (eCBT; $n = 37$), or computerised CBT self-administered treatment (cCBT; $n = 43$) for depression. From sessions 2–8, participants were asked to complete the Helpful Aspects of Therapy form (HAT). Participants completed 149 HAT forms representing a response rate of 45% (eCBT: 49%; cCBT: 42%). Reported helpful events included provision of information, monitoring, scheduling, restructuring, problem solving and distraction techniques and led to impacts such as learning new coping skills and behavioural changes, developing awareness and insight and achieving self-efficacy. Additionally, therapist responsiveness seems to have a worthy impact of feeling supported and validated as identified by the eCBT group, who solely reported helpful events such as acknowledgement/listening, advice and guidance and provision of compassion. Unhelpful events also surfaced for both groups, though more for the cCBT group, and included the burden of work, time and pace, issues with the content and its form of delivery, and technical problems, which led to impacts such as being frustrated, confused, irritated, disappointed, anxious and self-critical. CBT principles remain established in online work and, in addition, therapist responsiveness seems to have a worthy helpful impact, beyond any established CBT techniques or strategies.

Keywords: online treatments for depression; helpful and hindering impacts; significant events in therapy; depression; descriptive and interpretive framework

Depression is a serious and growing problem worldwide, displaying high rates of lifetime incidence, early age onset, high chronicity and role impairment (Richards, 2011). Studies have demonstrated elevated levels (12–15%) of depression in third-level students (Royal College of Psychiatrists, 2003). The consequent increase in

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accessing university mental health services (Mowbray et al., 2006; Rana, Smith, & Wlaking, 1999) has not been met by a proportionate increase in human resources; solutions are therefore sought (Rana et al., 1999).

Cognitive-behavioural therapy (CBT) is an established option for the treatment of depression (Hollon & DeRubeis, 2006). However, many with depression do not receive treatment (Kohn, Saxena, Levav, & Saraceno, 2004). Barriers to accessing treatment include a shortage of trained professionals, waiting lists, costs and personal barriers such as stigma. As a means of overcoming such barriers, recent years have seen the development of tailored CBT treatment programs using the internet (Marks, Cavanagh, & Gega, 2007). Research on computerised CBT (cCBT) for depression supports its efficacy (Andersson & Cuijpers, 2009; Richards & Richardson, 2012). Additionally, these developments may be pertinent for students who may demonstrate a preference for online formats (Ryan, Shochet, & Stallman, 2010).

Beating the Blues™ (Proudfoot et al., 2004) is one such self-administered program for depression treatment and has been recommended as a treatment option for people with mild or moderate depression (National Institute for Health and Clinical Excellence, 2006). The current study was one part of a broader project that uniquely examined the efficacy of two modes of delivering the Beating the Blues™ program within a university setting, one self-administered cCBT, and the other therapist-delivered e-mail CBT (eCBT) (Richards, Timulak, & Hevey, in review). Our aim in this study is to establish what client's identified as significant events (helpful and hindering) and their associated impacts in their respective online treatment.

Significant events research

Significant events research has existed for over 25 years. The research rationale is that significant events are the moments of the most fruitful therapeutic work in the case of helpful events, or the most problematic points in the case of non-helpful or 'hindering events' (Timulak, 2007). Some evidence supports that view (cf. review in Timulak, 2010). Notably, this type of research is client-centred as the clients are typically asked to identify what were the most helpful or non-helpful event(s) in the session. The majority of significant events studies collected data using either 'Interpersonal Process Recall' (later Brief Structured Recall) interview format (Elliott, 1986; Elliott & Shapiro, 1988) or by using the written HAT form (Llewelyn, 1988). Different approaches exist to analyse significant events, including an open-ended qualitative analysis leading to the establishment of types of events or the use of a pre-established taxonomy of events (Timulak, 2010). The former allows for a fresh look at the data and the latter allows for easier comparison across studies.

The research from individual face-to-face therapy has reported that client-identified events and their impacts make important contributions to the therapeutic relationship (e.g. events such as reassurance, feeling understood and personal contact) and some contribute to in-session outcomes (e.g. insight, relief, behavioural change, new feelings and empowerment; Timulak, 2007). For instance, Elliott (1985) in his pioneering work on helpful and non-helpful events in therapy described in-session outcome events associated with gaining a *new perspective*, *problem solution*, *problem clarification* and *focusing awareness*. He identified more relational events,

such as *understanding*, *client involvement*, *reassurance* and *personal contact*. His study also identified non-helpful events and these included *misperception*, *negative counsellor reaction*, *unwanted responsibility*, *repetition*, *misdirection* and *unwanted thoughts* (Elliott, 1985).

Though there are some suggestions that different therapies could lead to different impacts as perceived by clients, studies are limited (cf. Timulak, 2010). For instance, Llewelyn, Elliott, Shapiro, Hardy, and Firth-Cozens (1988) found that the most common significant event for psychodynamic therapy was *awareness* and for CBT *problem solution*.

The current study was the first to examine significant events (helpful and hindering) in online treatments for depression. Specifically, we wanted to know what participants found helpful and/or hindering in therapist-delivered vs. self-administered online CBT for depression. We embarked on this study with the hope of learning more about what may be working or not in this type of delivery format, so we could feed back this potentially fruitful information to those who develop online psychological treatments and also to those who implement and research such interventions.

Method

Design

In order to capture the clients' perceptions of helpful and hindering events and their impacts, a qualitative approach was deemed most suitable. For these reasons, a method informed by the descriptive and interpretive qualitative framework outlined by Elliott and Timulak (2005) was adopted.

Participants

Participants were registered students at an Irish University. The primary inclusion criterion for the main outcomes comparison trial was established using the Beck Depression Inventory (Beck, Steer, & Brown, 1996). Participants with scores ≤ 14 or >29 were excluded from the study as they were deemed to have less than mild or severe depression symptoms. Eighty participants began treatment, 37 were randomly assigned to the therapist-delivered asynchronous eCBT counselling group and 43 to the cCBT self-administered treatment group. The eCBT group was composed of 26 (70%) women and 11 (30%) men, their age range was 19–59 years, $M = 25.65$. The cCBT group was composed of 25 (58%) women and 18 (42%) men, their age range was 20–50 years, $M = 26.53$. The results of the main study regarding the efficacy of the treatments are reported elsewhere (Richards et al., in review).

Measure

HAT form (Elliott, Slatick, & Urman, 2001; Llewelyn, 1988) assesses the most helpful and hindering events in therapy. Participants were asked which in-session events they felt were the most important. An event can be anything that either they or their counsellor (voiceover narrator in self-administered condition) said or did. Further, they were then asked to describe what made the event helpful/important. HAT was administered at sessions 2–8.

Procedure

In the parallel comparison, trial participants were randomly assigned to one of the following two conditions: self-administered cCBT or therapist-delivered asynchronous eCBT.

Self-administered cCBT (Beating the Blues[TM])

Beating the Blues[TM] (Proudfoot et al., 2004) is an 8-session, self-help treatment. During the treatment, users identified specific problems and realistic treatment goals. They worked through cognitive modules that focused on the identification and challenging of automatic thoughts, thinking errors, distractions, core beliefs and attributional styles. The program included problem-directed behavioural components in which patients worked on activities such as scheduling, problem solving, graded exposure and sleep management. Finally, action planning and relapse prevention were considered. Beating the Blues[TM] uses interactive modules, animations and voice-overs to motivate and engage the user. A feature is a series of filmed case studies of fictional patients who model the symptoms of depression and help demonstrate the treatment by CBT.

Therapist-delivered eCBT

The condition consisted of two components: a text version of the Beating the Blues[TM] protocol (in email format where all multimedia elements such as the filmed case studies were delivered in text); and an opportunity for participants to write in free-text about issues that concerned them, this was additional to the prescribed CBT (Beating the Blues[TM]) framework. The reply from the counsellor included a response to their free-text alongside the specific CBT content for each session. Therefore, in addition to the established CBT content, the eCBT condition had the benefit of the therapist responsiveness. The therapists used the free-text part to cultivate responsiveness through (1) showing empathy and acknowledgement of emotions, (2) provision of guidance and information, (3) validation of successes, (4) promotion of self-care and social support and (5) building alliance.

The therapists' tailored response to the participants' free text in the eCBT condition represented 'therapist responsiveness' (Stiles, Honos-Webb, & Surko, 1998). We hypothesised that therapist responsiveness could enhance an online treatments outcome, partially basing this hypothesis on the fact that working alliance is a factor robustly related, in the small to medium range of effect size, with positive therapeutic outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) and partially basing it on the larger effect sizes reported in therapist-supported online depression treatment studies (Andersson & Cuijpers, 2009; Richards & Richardson, 2012).

Therapists

The eCBT was delivered by two therapists who worked at the university counselling service where the study was conducted. Both had specialist training in online counselling. Both were women and Irish and one had one and a half years experience and the other had three years experience, in conducting online counselling.

Data analysis

Descriptive-interpretive qualitative analysis (Elliott & Timulak, 2005) was conducted on the data collected using the HAT instrument to determine what were considered helpful and hindering therapy events and their impacts for both conditions and these were compared. The process of data analyses followed a number of distinct steps (Elliott & Timulak, 2005). The main steps involved in this approach to qualitative analyses are (1) to develop conceptual domains that will organise the data (here significant events and events' impacts); (2) to delineate meaning units, the smallest units conveying the essential meaning when out of their context and (3) assigning meaning units to categories capturing similarities in the meanings. Once the individual meaning units were assigned to the respective categories, these were suitably named and defined. This process of analyses requires organisation and ensures transparency. The process is organic, involving constant referencing between the source data and the emerging meaning units and categories.

The data was initially analysed by the first author and a preliminary helpful and hindering events list was compiled and associated impacts list, helpful and hindering too. Thereafter, this was reviewed by the second author who has many years of experience in qualitative research of this type. The second author had no knowledge whether the data came from eCBT or cCBT condition. This cycle occurred twice until a set of helpful and hindering events and associated impacts were conceived, named and defined. Thus, a taxonomy consisting of the categories of helpful and hindering events and their impacts and their definitions was created. This taxonomy was then used as a nominal rating scale by a post-graduate psychology student who assigned all of the data in the form of meaning units to the categories without prior knowledge of how the data were assigned by the authors. The results from the primary analyses carried out by the authors were then compared with a convenient sample of the results from the blind rating and an 80% agreement in terms of meaning units and categories developed was observed.

Results

In total, 149 HAT forms were completed during the treatment and study. In the eCBT condition from a total of 92 sessions, completed participants returned 65 HAT forms representing a response rate of 71%. In the cCBT condition from a total of 108 sessions, completed participants returned 84 HAT forms representing a response rate of 78%. In the eCBT condition, five participants returned all seven HAT forms, one returned four HAT forms and the remaining 12 returned between one and three HAT forms. In the cCBT condition, seven participants returned all seven HAT forms, five participants returned between four and seven HAT forms and the remaining six participants returned between one and three HAT forms. Given that, 80 participants began the treatment ($n = 37$ in eCBT and $n = 43$ in cCBT), the overall response rate for completed HAT forms was 45% (eCBT: 49%; cCBT: 42%).

The treatment program contained eight sessions and the mean number of sessions completed for each condition was eCBT: 3.97 (SD = 2.2) and cCBT: 4.05 (SD = 2.9). Of the participants who returned completed HAT forms, in the eCBT group, nine participants completed between five and eight sessions and nine completed between one and four sessions. In the cCBT group, 15 participants completed 5–8 sessions and three completed between one and four sessions.

Table 1. Instances of helpful events and helpful impacts.

Helpful events	cCBT $n=18$ No.	eCBT $n=18$ No.	Helpful impacts	cCBT $n=18$ No.	eCBT $n=18$ No.
Provision of new information	11/18	3/18	Learning coping skills/ behavioural change	7/18	8/18
Monitoring/recording	9/18	4/18	Awareness and insight	18/18	12/18
Scheduling/planning	9/18	9/18	Achievement/self-efficacy/ empowerment	18/18	13/18
Restructuring	15/18	9/18	Self-esteem	3/18	6/18
Summarising	6/18	1/18	Support/validation	1/18	12/18
Sharing	4/18	0/18	Connection	5/18	4/18
Distraction techniques	5/18	2/18	Relief	1/18	2/18
Problem solving techniques	6/18	4/18			
Relaxation techniques	3/18	0/18			
Graded exposure	2/18	0/18			
Encouragement	1/18	3/18			
Advice/guidance	0/18	3/18			
Disclosing	1/18	4/18			
Acknowledge/listening	0/18	8/18			
Provision of compassion	0/18	2/18			

Note: No. - Refers to the number of individual counts of the item/of the total number of participants.

Altogether 15 helpful events (provision of new information, monitoring/recording, scheduling/planning, restructuring, summarising, distraction techniques, problem solving techniques, relaxation techniques, graded exposure, encouragement, advice/guidance, disclosing, acknowledgement/listening and provision of compassion) and seven associated impacts (learning coping skills/behavioural change, awareness and insight, achievement/self-efficacy/empowerment, self-esteem, support/validation, connection and relief) were reported. In total, five hindering events (burden of work, time/pace, technical, content of treatment and form of treatment) and seven associated impacts (self-critical, frustrated, irritated, confused, painful insight, anxious and disappointed) were reported. The complete list of helpful and hindering events and impacts and their associated definitions can be obtained from the authors.

Both treatment groups shared in attaining significant impacts such as developing awareness and insight, realising achievements, attaining self-efficacy, feeling empowered and learning new coping skills, all of which contribute to in-session outcomes (Timulak, 2010). The results displayed in Table 1 show a single count for each qualitative item, helpful events and their associated impacts, for the individuals in both groups.

The achievement/self-efficacy and empowerment category was the highest rated impact in the eCBT group (13 of 18) and joint highest alongside awareness and insight for the cCBT group (18 of 18 for both categories). In addition, both groups had a large number of participants who identified that they learned new coping skills that caused behavioural change (8 out of 18 eCBT and 7 out of 18 cCBT).

Significantly, the eCBT group had a very high rating for the impact support and validation (12 of 18) and this stands in contrast to the single rating by the cCBT group. The impact corresponds favourably to the event of being acknowledged

Table 2. Instances of hindering events and hindering impacts.

Hindering events	cCBT $n=18$ No.	eCBT $n=18$ No.	Hindering impacts	cCBT $n=18$ No.	eCBT $n=18$ No.
Burden of work	2/18	2/18	Self-critical/blaming	0/18	1/18
Time/pace	4/18	3/18	Frustrating	6/18	6/18
Technical	3/18	0/18	Irritating	3/18	0/18
Treatment content	5/18	6/18	Confusing	3/18	1/18
Form of treatment	3/18	2/18	Anxious	2/18	0/18
			Disappointing	2/18	1/18
			Painful insight	2/18	0/18

Note: No. - Refers to the number of individual counts of the item/of the total number of participants.

and listened to, a category rated highly (9 out of 18) by the eCBT group and not present at all in the cCBT group (0 out of 18). Connection is an impact noted by both groups, and relates to sharing personal experience or benefitting from other peoples shared experience.

The HAT data also accounted for what participants found hindering in their experience of online treatment. Table 2 shows a single count for each qualitative item concerning hindering events and their impacts for individuals in both groups.

Hindering events can cause significant negative impact that have the potential to cause dissatisfaction, ruptures in the therapy and eventual withdrawal (Safran, Muran, Wallner Samstag, & Stevens, 2002). Five events were named as hindering and four of them surfaced for both groups. Notably technical issues did not surface for the eCBT group. The most notable impact for both groups was participants being frustrated, followed by confused and disappointed. The cCBT group had a greater number of hindering impacts recorded and higher numbers subscribed than had the eCBT group.

Discussion

The current study sought to examine what participants found helpful and/or hindering in therapist-delivered vs. self-administered online CBT for depression. The results give a unique insight into what was considered useful and important and also what outcomes can be achieved from specific aspects of the treatment program and other concrete events that occurred within treatment. Certainly, it is the case that the variety of events reported upon could contribute to the acquisition of new cognitive and behavioural skills and strategies. The cCBT group gives mention to the complete range of cognitive and behavioural strategies employed in the treatment program from monitoring and recording thoughts and feelings to graded exposure technique. The eCBT group is lighter especially when it comes to naming some of the more specific CBT techniques like distraction, relaxation or graded exposure. Nevertheless, some participants in both groups named as important that they learned new coping skills and experienced behavioural changes.

For both groups, several in-session impacts were identified and frequently stated as important, these included developing awareness and insight, achievement, self-efficacy and empowerment. These are similar to in-session outcomes reported from face-to-face studies (Booth, Cushway, & Newness, 1997; Elliott, 1985; Llewelyn, 1988; Llewelyn et al., 1988; Martin & Stelmaczonek, 1988). It can also be noted that some of these categories were rated higher for the cCBT group (awareness and insight 18/18, achievement, self-efficacy, empowerment 18/18) than for the eCBT group (awareness and insight 12/18, achievement, self-efficacy, empowerment 13/18). It is likely that the higher ratings for such impacts were related to the greater importance placed on intrapsychological processes by participants in the cCBT groups in the absence of more relational events and their impacts. This seems to be in line with the fact that the interpersonal impacts of being supported and validated (which are also to be found in face-to-face studies; cf. Booth et al., 1997; Elliott, 1985; Timulak, 2007) were rated highly by the eCBT group (12 of 18) and barely appeared for the cCBT group (1 of 18). In this case it is likely that the impact was related to events reported by the eCBT group such as, encouragement, advice and guidance, disclosing, being acknowledged and listened to, and the provision of compassion, all of which featured highly for the eCBT group and featured less so for the cCBT group. It makes sense that this would be the case as the eCBT group treatment was therapist-delivered and therefore had a greater presence of events and impacts associated with the therapeutic relationship and its consequent impact.

Interestingly, the impact of connection was named for both groups; probably it functioned differently for both groups. It is likely that the sharing of personal information with the therapist and receiving their response in the eCBT group facilitated a sense of connection whereas in the cCBT group it was likely to have arisen out of the experience of listening to the personal stories that the program uniquely provided in video format.

It seems that in online CBT treatments for depression the various strategies and skills associated with the specific content of the interventions have a noteworthy impact for both groups. Additionally, the role of a responsive therapist, beyond the established CBT intervention, seems to be valued highly for participants in the eCBT group. It appears that the eCBT group benefitted from a therapist-led intervention and the opportunity to write in free text about their concerns and receive a response to those concerns. Therapist responsiveness may have detracted them from the specific CBT content, but they realised the successful outcomes from treatment. Indeed, the reader will know that the main research trial (Richards et al., in review) reported that the outcomes for both groups were equal at post-treatment and no significant differences were shown between the groups which suggests that there existed two routes to treatment success, one (cCBT) solely through non-relational CBT techniques and strategies and one (eCBT) that also benefited from a relational element (Richards et al., in review). Therefore, it would be interesting to investigate further whether a therapist-delivered non-CBT intervention based on exchanges of free text, such as those described by Richards (2009) and Efstathiou (2009), would equal outcomes from a self-administered cCBT program.

Compared to face-to-face studies (Timulak, 2010), hindering events were notably less prevalent in our sample. They seemed to surface quite equally for both groups, though the participants in the cCBT condition reported a greater variety of hindering impacts. Perhaps this is indicative of the impact of therapist responsiveness to

ameliorate against any ruptures in treatment. The most notable hindering impact was that of frustration. The source could have been a variety of different events that occurred throughout treatment such as feeling overwhelmed with the burden of work involved in the treatment. For example, events such as the time and the pace of the treatment surface as important elements that caused frustration for both groups in the current study cohort. Time and pace considers issues such as the amount of time demanded by the program and the availability of the participant to schedule the demands of the program. For students this can become heightened, such as at exam times, when other pressures mount. The impact brings to the fore issues regarding the delivery of online treatments, the need for flexible delivery and responsive implementation accounting for the user's needs and their external circumstances.

Misunderstanding and disappointment dominate the face-to-face significant hindering events literature (Llewelyn, 1988; Timulak, 2010) and we found it, occasionally, in our sample as well. Both groups also identified disappointment as an impact. In the cCBT group, some users found the video case histories caused them disappointment, also some found the lack of choice in the program a disappointment. For the eCBT group disappointment surfaces with the content where one user felt it was more friendly advice than something they could really reflect upon.

Both groups identified confusion as a hindering impact. These were instances where the program content caused the user confusion; mostly it was about being left without a clear understanding of treatment elements or indeed homework tasks. Irritating is another impact mentioned only by the cCBT group and relates mostly to form of delivery where at times participants became exasperated with the sound of the background music or with the sound of the voiceover accompanying the program. It seems obvious that the design of such programs can include abilities to switch off music or change voiceovers and these simple additions may enhance treatments.

User testing of interventions needs to be thorough so that developers can identify potential troublesome content and make any necessary changes. It seems clear that if users experience confusion, irritation or disappointment with regard to the content being delivered, this increases the risk of dropout and potentially colours their assessment of the usefulness of therapy in general. Items and issues associated with content and the form of its delivery are largely design related and feedback from users needs to be examined. Employing technology to deliver content allows for a wide range of choices in how that content can be delivered to a user. Experimenting with mobile technology, virtual reality and other modes of delivery may prove beneficial in the design and delivery of content.

Painful insight arises out of working through the content of the program and engaging in the variety of exercises. At times, a user can receive a personal insight that may have significant personal resonance. These are key points in the therapeutic work and have significance for future development of healthy ways of thinking and behaving. Participants in the eCBT group could share and explore such insights with their online counsellor. The insights in the cCBT group were arrived at alone. A key question is how the user deals with these, what do they do with such insights? Therapeutic management of emotional insights is an important point in the delivery of any therapeutic intervention. It makes a strong argument for responsiveness at such points to address what the client may need at these times. For instance, Elliott (1985) reported that clients who arrived at insights were ready for

interpretation as they were in the process of deepening their understanding and indirectly were asking for help from the therapist in this task.

Limitations

The principal limitation to note is the research attrition from the current study. Of the 80 participants who began treatment 36 (eCBT: 18 of 37; cCBT: 18 of 43) returned HAT forms, a response rate of 45%. The study is the first in establishing helpful and hindering events and their impacts in online treatments and as the sample is small caution is advised in generalising the findings to other similar studies. Although the use of smaller sample sizes are acceptable in qualitative research of this type (Hill, 2012). Additionally, the study has demonstrated the efficacy of cCBT for adult students with moderate depressive symptoms and who have self-selected for treatment, how well they inform the treatment for other groups, such as severely depressed, remains open to further study (Richards et al., in review). A further potential limitation, with the use of qualitative methods is that the subjective perspective of researchers may favour one condition over the other. However, to guard against such a possibility both the second author and the independent rater in their analysis of the data did not know from which group (eCBT or cCBT) the data came.

Conclusion

To conclude, the HAT data has provided some unique insights into the individual who is being treated from session-to-session. The established CBT principles remain established in online work and, in addition, therapist responsiveness seems to have a worthy impact, beyond any established CBT techniques or strategies. Remembering that participants were subjects in a randomised parallel group study (Richards et al., in review) that demonstrated that CBT content can be successfully delivered online and that participants consequently identified as important that they, for instance, could learn new coping skills and strategies in managing their depression. Participants seem to be able to develop significant awareness and insight and together with the use of the CBT strategies and skills develop their self-efficacy, feel empowered and contribute positively to their self-esteem. Additionally, for participants in the eCBT condition, support and validation from a responsive therapist seems to contribute positively to therapy's impacts. Connection can be created online in different ways through the attention of a responsive therapist and also through the sharing of personal stories as evidenced in the videos included in the self-administered program. Over and above text-based information, the delivery of content in multimedia format has a positive impact for users.

   The data also highlights the necessity for flexible and responsive delivery of online treatments that takes account of the other extraneous demands in users lives, in this case the lives of students. Programs in their delivery can include content that may be problematic for users, causing confusion and frustration. There is a need to carry out comprehensive user testing to help identify any such content and make changes. The pervasiveness of technology and its use in people's lives creates a demand for the use of the latest technologies available, innovation and diversity in how content, exercises and tasks are delivered. Programs can be experienced as inflexible and the need to

incorporate user choice and control over accessing suitable content that matches user's needs is something designers can incorporate into the development of online programs. Technical support for program users is something also to be considered in the implementation of online treatments. Lastly, professionals need to consider the therapeutic impact of the interventions for users, for instance, when users experience painful insights, and how these can be adequately managed.

Acknowledgements

Notes on contributors

Derek Richards works in the area of development and research in online mental health interventions. He has pioneered such interventions at the University of Dublin, Trinity College Dublin, Ireland. He has presented and published nationally and internationally in the area.

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